Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Certification of Medical Education

Applicant: The board requires each medical school where you received all or part of your medical education to complete this form and attach an official transcript of your education. Complete the top portion and page two of the form only and submit the form to the medical school(s).

School: Complete this form, attach an official transcript of the applicant's education, and mail the completed form directly from the medical school to the **Iowa Board of Medicine.** A translation of any transcript not in English is also required**.** Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Applicant)

received their medical education at _____
(Name of School)

located at _____
(Address, City, State, Zip, Country)

From _____ To _____ Date Diploma Received _____
(Month/Year) (Month/Year) (Month/Year)

Granted a diploma with the degree of DOCTOR of _____

Was the school accredited by the Liaison Committee of Medical Education or the American Osteopathic Association at the time the applicant graduated?

Yes _____ No _____ Not Applicable _____

Is the above school name different from when the applicant attended? Yes _____ No _____

List previous school name: _____

Any disciplinary action or derogatory information on file? Yes _____ No _____
If yes, provide a copy of documentation related to the action or information.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the President, Dean, Secretary, or Registrar:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information—Certification of Medical Education

The applicant must sign this form and submit it with the Certification of Medical Education. The medical school may retain this release of information for their own records.

I, _____(print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Physician Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/ drug abuse or mental health information.